REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

File Number: _____

You have the right to request the Department of Health Services (DHS) to restrict the use and disclosure of your Cancer Detection Section information to carry out treatment, payment or operations. You also have the right to request that DHS not disclose Cancer Detection Section information to a family member, relative, or friend involved with your care or payment for your health care. DHS may not be able to agree with your request. This form must be accompanied by a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification (see Page 2). You may also be required to send documentation verifying your address (see Page 3). Mail this completed form to:

Cancer Detection Section
Attention: HIPAA Manger
MS-7203, P.O. Box 997413
Sacramento, CA 95899-7413

<table>
<tr><th colspan="4">INDIVIDUAL INFORMATION</th></tr>
<tr><td colspan="2">LAST NAME</td><td>FIRST NAME</td><td>MIDDLE INITIAL</td></tr>
<tr><td colspan="2">ADDRESS</td><td>CITY/STATE</td><td>ZIP CODE</td></tr>
<tr><td colspan="2">Cancer Detection Programs: Every Woman Counts
RECIPIENT ID NUMBER*</td><td>DATE OF BIRTH</td><td>SOCIAL SECURITY NUMBER*</td></tr>
<tr><td>DAYTIME PHONE NUMBER

(____) _____</td><td>ALTERNATE PHONE NUMBER

(____) _____</td><td>BEST TIME TO REACH YOU

_____</td><td>EMAIL ADDRESS

_____</td></tr>
</table>

*We use these numbers to make sure information is restricted only by appropriate persons.
If you don't supply at least one of the numbers, we will be unable to honor your request. You can get your Recipient ID Number from the place where you received medical services paid for by the Cancer Detection Programs: Every Woman Counts.

CHECK ALL THAT APPLY

☐ **I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES RESTRICT USE AND DISCLOSURE OF MY CANCER DETECTION SECTION PROTECTED HEALTH INFORMATION IN CARRYING OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AS FOLLOWS:**

☐ **I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES RESTRICT THE DISCLOSURE OF THE CANCER DETECTION SECTION PROTECTED HEALTH INFORMATION TO THE FOLLOWING PERSONS:**

IN THE SPACE ABOVE PLEASE PROVIDE THE NAMES OF ANY FAMILY MEMBERS, RELATIVES OR OTHERS TO WHOM YOU DO NOT WANT DHS TO DISCLOSE INFORMATION.

IDENTIFYING INFORMATION

☐ COPY OF PHOTO IDENTIFICATION ATTACHED

ACCEPTABLE IDENTIFICATION IS A CALIFORNIA DRIVER'S LICENSE, CALIFORNIA DMV IDENTIFICATION CARD, PASSPORT, MATRICULA CONSULAR OR STATE OR FEDERAL EMPLOYEE ID CARD.

I UNDERSTAND THE DEPARTMENT OF HEALTH SERVICES MAY NOT AGREE TO REQUESTED RESTRICTION(S), BUT WILL NOTIFY ME OF ITS RESPONSE TO MY REQUEST.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

SIGNATURE_____ DATE_____

☐ **IF NO PHOTO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.**

NOTARIZED BY _____ ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

☐ IF THE PHOTO IDENTIFICATION DOESN'T SHOW THE ADDRESS ON PAGE 1 OF THIS FORM, PLEASE PROVIDE A PHOTOCOPY OF ONE OF THE FOLLOWING TO CONFIRM YOUR PRESENT ADDRESS: UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.

DHS is committed to protecting the information you provide us. To prevent unauthorized access or disclosure, to maintain data accuracy, and to ensure the appropriate use of the information, DHS has in place appropriate physical and managerial procedures to safeguard the information we collect.